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INTERIM REPORT OF THE

HEALTH PROMOTION TASK FORCE

CHOICES FOR A HEALTHY FUTURE

Submitted to the Steering Group of the Health Advisory Network, Manitoba Health

February 1991

If you build castles in the air

Your work need not be lost,

That's where they should be.

Now put foundations under them

David Henry Thoreau

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I am grateful to the Health Promotion Directorate which provided the Task Force with office space, and a secretary, and I express on behalf of the Task Force our thanks to our secretary, Paul Fieldhouse, who kept us on track, arranged our appointments, gave valuable assistance in finding research material, in organizing a vast quantity of information and who provided constant support and inspiration to the Chair.

Finally I say "thank you" to Jane Griffith our writer, for her assistance in organizing, synthesizing, writing and editing information in this report.

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EXECUTIVE SUMMARY

The Health Promotion Task Force was struck in January 1990, with terms of reference set by the Steering Committee of the Health Advisory Network. The Task Force was asked to make recommendations regarding:

> Appropriate mechanisms through which major promotion and prevention issues can be addressed by all sectors (government, private industry and business, community groups) with a view to improving coordination of healthy public policy.
>
> Special target groups at which programs and services should be directed on a priority basis
>
> A process through which health care systems or public policy shifts can be achieved so as to focus on health promotion and disease prevention if existing services are deemed to be inadequate
>
> Means by which private sector initiatives in health promotion and disease prevention may be encouraged
>
> Active participation in health promotion policy formulation in the community

To make its recommendations, the Task Force adopted a plan which included a review of current literature, public hearings and expert presentations. The response to submit briefs and/or appear at public hearings was overwhelming. Altogether, 140 separate oral and/or written presentations were made.

The Task Force found that the recommendations requested by the Steering Committee of the Health Advisory Network were in many cases interrelated. Therefore, the recommendations made by to Task Force are organized into four challenges which represent the major issues for consideration. These are:

1. A Leadership Challenge - to put health promotion on the political agenda through government leadership, commitment and structure.

2. A Community Development Challenge - to promote a community development approach to health programming at local and regional levels.

3. An Inequities Challenge - to address differences in health status of sub-groups within the Manitoba population.

4. An Education and Research Challenge - to promote a strong theoretical, philosophical and technical base for Health Promotion.

Throughout these challenges there are two strong themes which emerge; these are the need for healthy public policy, and the '4Cs': co-ordination, co-operation, collaboration and communication. There is a tremendous need for government and non-government organizations, communities and individuals to work together to meet common goals.

The Health Promotion Task Force has identified these four challenges that have the potential to impact positively on the health of Manitobans, and to enable individuals and communities to increase control over and improve their health. This summary presents the challenges and recommendations made by the Task Force to the Minister of Health.

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1.8. AMEND THE CURRENT DEPARTMENT OF HEALTH ACT AND REGULATIONS

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1.12. GIVE PUBLIC RECOGNITION TO THE ACHIEVEMENTS OF CITIZENS IN PROMOTING HEALTH

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1.14. ESTABLISH A COORDINATING GROUP FOR INTERSECTORAL IMPLEMENTATION OF CANADA'S GUIDELINES FOR HEALTHY EATING

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4.12. ESTABLISH AND MAINTAIN A HEALTH PROMOTION CLEARINGHOUSE

4.13. SUPPORT INTERSECTORAL COOPERATION BY THE PROVISION OF APPROPRIATE EDUCATIONAL OPPORTUNITIES

Throughout the text of the report there are a series of boxed highlights which we call 'snapshots'. These include examples of programmes and activities, statistics, quotes from the literature or from presentations made to the Task Force. Their purpose is to illustrate the narrative material and to provide support for recommendations. A full list of presenters and a bibliography are included at the end of the report.

INTRODUCTION

MANDATE

The Health Promotion Task Force was struck in January 1990, with terms of reference set by the Steering Committee of The Health Advisory Network:

> To determine the adequacy of resources in the health care sector directed toward health promotion and disease prevention
>
> To review existing health promotion and disease prevention activities in Manitoba
>
> To review the process of policy formulation in health care programmes related to health promotion and disease prevention
>
> To review the policy paper entitled "Partners for Health: New Directions for the Promotion of Health in Manitoba"

Following the review process the Task Force was asked to make recommendations regarding:

> Appropriate mecnanisms through which major promotion and prevention issues can be addressed by all sectors (government, private industry and business, community groups) with a view to improving coordination of healthy public policy.
>
> Special target groups at which programmes and services should be directed on a priority basis
>
> A process through which health care systems or public policy shifts can be achieved so as to focus on health promotion and disease prevention if existing services are deemed to be inadequate
>
> Means by which private sector initiatives in health promotion and disease prevention may be encouraged
>
> Active participation in health promotion policy formulation in the community

PROCESS

To accomplish its goals, the Task Force adopted a plan which included a review of current literature, public hearings and expert presentations.

A wide range of government, non-government, private sector and community organizations were sent written invitations to submit briefs to the Task Force and/or appear at public hearings. In addition, these hearings were advertised in local newspapers as appropriate. In Winnipeg, arrangements were made for one set of hearings to be conducted in French.

The response was overwhelming. Altogether, 140 separate oral and/or written presentations were made, covering a wide range of lifestyle, environment and policy issues. In addition, six invited speakers provided expert insights to the Task Force.

A complete list of presenters is appended to this document

DEFINITIONS

Members of the Task Force reviewed numerous contemporary documents in the health promotion field. There are differing interpretations of the meaning and intent of health promotion, and the concept of health itself has changed radically during this century. The Task Force endorses the current WHO definition of health which is:

"... the extent to which an individual or group is able on the one hand, to realize aspirations and satisfy needs; and on the other hand to change or cope with the environment. Health is thus seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources as well as physical capacities".

Health promotion is "... the process of enabling people to increase control over and to improve their health. It provides an avenue for dealing with emerging challenges to health in everyday living".

Experience with the new concept of health promotion has defined five principles:

1. Health promotion actively involves the population in the setting of everyday life rather than focusing on people who are at risk for specific conditions and in contact with medical services.

2. Health promotion is directed towards action on the causes of ill-health.

3. Health promotion uses many different approaches which combine to improve health. These include education and information, community development and organization, health advocacy and legislation.

4. Health promotion depends particularly on public participation.

5. Health professionals - especially those in primary health care - have an important part to play in nurturing health promotion and enabling it to take place.

CHALLENGES AND THEMES

The Task Force Report is organized into four challenges, which represent major issues for consideration. In addition, two strong themes emerged from our reading and from public hearings; these were healthy public policy, and the "4Cs"; co-ordination, co-operation, collaboration and communication.

Healthy Public Policy

We agree with Marilyn Knox, Executive Director of the Ontario Premier's Council on Health Strategy, that: '...healthy public policy (recognizes) that there is a variety of critical influences on health, many of which are beyond the control of individuals or the traditional health care system. It is characterized by the involvement of new partners from diverse backgrounds, including consumers, and focuses on equitable results'.

Health promotion goes beyond health care and makes health an agenda item for policy makers in all areas of governmental and organizational action.

Many of the recommendations throughout this report emphasize the pressing need for healthy public policy. We applaud the leadership of the Manitoba government in creating a Cabinet level committee and Interdepartmental Steering Group for healthy public policy. These structures are essential to the success of comprehensive measures to address the determinants of health in our society, acknowledging as they do that 'achieving health for all' is a task for everyone.

The 4C's: Coordination: Cooperation: Collaboration: Communication

In one way or another, the 4C's were mentioned by nearly every group from whom the Task Force heard. There is a tremendous need for government and non-government organizations, communities and individuals to work together to meet common goals. Collaborative programming and problem solving must be promoted across all sectors of society since successful health promotion efforts will hinge on the development of successful partnerships rather than the actions of any single organization. The 'Partners for Health' concept could be an excellent means of encouraging collaborative projects, but it requires that the government be content to be an equal partner, and not attempt to retain control or reserve decision-making power to itself. 'Partners for Health' is already seen by many as a 'government programme' rather than as a cooperative venture.

In order for various sectors to cooperate effe~tively there must be a shared understanding of the processes and advantages of the partnership approach. Manitoba Health could show leadership in encouraging intersectoral collaboration by holding conferences, training sessions and public forums to increase knowledge and skills in health promotion.

Presenters to the Task Force frequently criticized government for its poor record in communicating with non-government groups; for delaying decisions; and for being unreliable and unpredictable in its support for health promotion initiatives. An effort must be made to address these perceptions and to respond more quickly and consistently to community concerns.

THE CHALLENGES

Effective health promotion will require a mix of individual, community, institutional, societal and political actions. The Health Promotion Task Force has identified four challenges to the Minister that have the potential to make a positive impact on the health status of Manitobans and to enable individuals and communities to increase control over and to improve their health.

These challenges are:

I. LEADERSHIP

In addressing its terms of reference the Health Promotion Task Force was to develop a new focus for health care in Manitoba, emphasizing health promotion and disease prevention. The structures that presently exist can not do what is now required. The process of shifting the medical care system which is curative, to a health care system which emphasizes wellness, necessitates a change in structure of the delivery system and a reallocation of resources.

II. COMMUNITY DEVELOPMENT

A community development approach to health programming should be adopted at local and regional levels. Communities want to be more involved assessing needs and developing strategies to meet these needs. This message was loud and clear from the submissions and hearings held in Winnipeg and throughout rural and northern Manitoba.

III. REDUCING INEQUITIES

Differences in health status of sub-groups within populations have been clearly described and documented in many studies and reports. Factors such as education, literacy, housing, transportation, a clean water supply, employment, social support and economics greatly influence the health of an individual or family. There is a consistent strong association between low socio-economic status and poor health.

IV. EDUCATION AND RESEARCH

Good health promotion practice requires a strong, theoretical, philosophical and technical base. However, there is little formal education and training available in health promotion theory, strategies and skills - at any level. Whether we are looking at comprehensive university courses for health professionals, or skills training for lay persons, there is a great need for educational development in this field.

CHALLENGE I - LEADERSHIP

In addressing its terms of reference the Health Promotion Task Force was to develop a new focus for health care in Manitoba, emphasizing health promotion and disease prevention. The structures that presently exist can not do what is now required. The process of shifting the medical care system which is curative, to a health care system which emphasizes health promotion, requires a change in structure of the delivery system and a reallocation of resources.

RECOMMENDATIONS:

1.1. ESTABLISH AN OFFICE OF HEALTH PROMOTION

The policy document 'Partners for Health: A New Direction for the Promotion of Health in Manitoba' refers to a higher profile for health promotion, and to a new mandate for healthy public policy. It is necessary to reposition health promotion in the organizational chart to provide both the profile and power of action desired. The Office of Health Promotion, reporting directly to the Minister of Health, will provide a means to coordinate and focus existing community health promotion initiatives and future health promotion activities throughout government. It will support the Interdepartmental Steering Committee for Healthy Public Policy, be responsible for devising community development strategies, coordinate a health promotion media campaign, and support lifestyle programming.

The current infrastructure does not readily allow for cooperative and coordinated health promotion activities in all sectors of government. The Office of Health Promotion should be the heart of the governments preventive health efforts. [Appendix A]

1.2. DEVELOP A WORKING DEFINITION OF HEALTH PROMOTION

The definition adopted by the Task Force while useful from a theoretical point of view, is not readily understood by the lay public. A comprehensive media strategy is recommended to promote an understanding of this new public definition; to create an awareness of options and choices; and to recognize health promotion activities.

1.3. ESTABLISH PROVINCIAL HEALTH GOALS

Health goals have been developed and implemented in many jurisdictions both within Canada and internationally. They are a vital tool to form a framework for planning, priorizing, and evaluating health promotion programs. Goals will provide measurable outcomes for health promotion efforts, include standards, and specific objectives as well as detailed strategies for attainment. These goals will be established to address major health problems, and to call for achievable improvements in the health potential of Manitobans. Goals will be developed which pertain to a population as a whole, as well as to projects and programs on a target group by target group basis.

1.4. EXPAND 'PARTNERS FOR HEALTH' ACTIVITIES

The Task Force commends Manitoba Health for its 'Partners for Health' policy initiative. Success with this approach is evident in such programmes as "Smoke-Free Grads 2000"; "Fire! Fire!"; and the Workplace Health Promotion Grants scheme. The momentum must be maintained by encouraging and supporting health promotion initiatives of citizen, business and professional groups. Partnerships could be encouraged and supported by linking program funding to initiatives that demonstrate cost-sharing amongst various levels of government, business, non-government organizations, and community groups. In developing partnerships, differing responsibilities and the limited levels of resource and expertise available within communities should be acknowledged.

Existing partnerships with professional organizations involved in health promotion such as the Manitoba Public Health Association, the Manitoba Medical Association, the Manitoba Association of Registered Nurses and the Health Promotion Directorate of the Federal Government, should be strengthened.

1.5. ESTABLISH A "SMALL PROJECT" FUND FOR COMMUNITY HEALTH PROMOTION INITIATIVES

This is an effective way of using existing funds for local community health promotion. Currently there are several community health promotion initiatives which are proving successful in meeting community needs and which deserve continuing support. A ceiling of between $10-20,000 per project is suggested. This fund would thus differ from the Health Services Development Fund (which the Task Force supports) which is aimed at larger projects with higher costs. (Appendix B)

1.6. PROVIDE ASSISTANCE TO COMMUNITIES IN DEVELOPING FUNDING PROPOSALS

One of the largest barriers to communities in undertaking health promotion activities is their limited expertise at developing funding proposals. The result is that they spend a great deal of time applying for funds with no guarantee of success. This leaves community groups frustrated and disillusioned. Assistance to communities in grantsmanship procedures would help resolve this problem.

1.7. DEVELOP AND IMPLEMENT A QUALITY ASSURANCE PROGRAM

Today's society is under an enormous pressure to reduce costs, while at the same time, maintaining quality. The single most useful tool which will enable us to meet these objectives is one which systematically analyzes the work being done, establishes appropriate procedures and ensures that work is performed consistently and in the proper manner. (Appendix C) A Quality Assurance Program should be implemented across the health department to develop community based health outcomes which are measurable and consistent with Provincial Health Goals; to establish efficient and effective means of program delivery; and to provide ongoing evaluation of community initiatives. One of the reasons health care spending in Manitoba will continue its upward spiral is that quality assurance is not in place.

With quality assurance in place, proponents of particular expenditures would need to provide evaluation processes and evidence of efficacy to receive funding. Present health care expenditures are being made with insufficient evidence of cost-effectiveness.

1.8. AMEND THE CURRENT DEPARTMENT OF HEALTH ACT AND REGULATIONS

The Act should include a mandate for health promotion activities by public health and other government staff. Without this, health promotion is seen as an "add-on", to be done if there is sufficient time, money and personnel. A clear written mandate would set in motion the necessary action for sufficient resource allocation to ensure health promotion is a priority.

> **'Mandatory Health Programs and Services'**
>
> 6. Nutrition, including provision of consulting and educational services...
> 7. Public health education, including education in the prevention and control of lifestyle diseases.
>
> Ontario Health Protection and Promotion Act, 1983 (Revised September 1988)

1.9. DESIGNATE AN ADDITIONAL 3% OF THE HEALTH BUDGET FOR HEALTH PROMOTION EFFORTS.

Over the past two decades, while the health care budget has continued to expand, health promotion and disease prevention efforts have not received sufficient funding. We must increase the scale of our operations in health promotion in order to control spiralling health care costs. As a beginning, the Minister should commit an additional amount equal to approximately 3 percent of the total health care budget to health promotion initiatives. This would see an increase from the current figure of approximately $3.4m to $44.0m (Appendix D Manitoba Health Costs)

1.10 INITIATE ENVIRONMENTAL LEGISLATION AND ENSURE THAT HEALTH CONSEQUENCES ARE CONSIDERED

Clean air, toxic contaminants, waste control and protection of our water are part of a very large wave of concern that is presently sweeping our country. The Federal Governments' Environmental Protection Act and the 1992 goal for the Green Plan indicate that much is needed to be done in Manitoba. Other provinces, including Ontario, Nova Scotia, Saskatchewan, Alberta and British Columbia are demonstrating rigorous progress toward enacting environmental legislation and predetermined controls. Manitoba's Environmental Health Directorate, by comparison, is reflecting a weakness in this area, and requires upgrading to meet contemporary expectations. Relative to recent Canadian environmental initiatives, Manitoba is rapidly falling behind.

1.11 GIVE PUBLIC RECOGNITION TO THE ACHIEVEMENTS OF HEALTH PROFESSIONALS AND AGENCIES IN PROMOTING HEALTH

Successes should be celebrated, by exploring a means of publicizing and rewarding professional efforts in health promotion. Some current examples include;

1) the work of the Council for a Tobacco Free Manitoba in advocating for smoke free spaces in workplaces;
2) the Manitoba Medical Association's partnership campaign to promote the use of bicycle helmets.
3) The Planned Parenthood of Manitoba Immigrant Health Education Program

1.12 GIVE PUBLIC RECOGNITION TO THE ACHIEVEMENTS OF CITIZENS IN PROMOTING HEALTH

Communities should be rewarded and recognized for the efforts they make to improve the health of their members. Many presenters to the Task Force were already involved in successful health promotion initiatives in their own communities. In Interlake alone, we can point to HUB and P.R.I.D.E. in Selkirk, and the Health Promotion Committee in Gimli as excellent examples of citizen concern and action.

1.13 DEVELOP A COORDINATED FOOD AND NUTRITION POLICY, LINKING NUTRITION AND HEALTH WITH AGRICULTURE, EDUCATION, FITNESS, SOCIAL SERVICES, ENVIRONMENT AND OTHER RELATED SECTORS.

The need for integrated food and nutrition policies at a provincial level is articulated in the recent report: "Nutrition Recommendations: A Call for Action" (Health & Welfare Canada, 1989). We see this as a fundamental component of healthy public policy. It is well recognized that nutrition plays a key role in the health of a population throughout the life cycle. Poor nutrition is implicated in many of the chronic diseases which currently burden the health care system. Physical and mental development in young children may also be adversely affected by inadequate diets. Nutrition education strategies aimed at influencing personal dietary choices have limited impact unless supported with a nutritious, affordable food supply.

Many non-nutritional factors can influence the success or failure of nutrition and food policies. Consequently, in addition to being physiologically sound, they must be politically viable, economically feasible and culturally acceptable. To achieve this, food and nutrition policies must have the credibility provided by scientific and epidemiological evidence, have political and technical support, and be regarded as necessary and convenient by the consumer.

All this indicates that the development and implementation of food and nutrition policies require multisectoral government actions. These actions need to be coordinated to be effective; they should involve the whole food chain, from the production or importation of food through to its consumption.

Manitoba Health should work with other government departments, through the Healthy Public Policy Committee of Cabinet, to:

* Initiate coordinated, comprehensive food and nutrition policies in schools
* Fully integrate nutrition into the curricula at all levels in the formal education system, including teacher education programmes
* Ensure that foods served in Manitoba schools are consistent with Canada's Guidelines for Healthy Eating
* Review dairy product legislation regarding altered-fat food products
* Examine social assistance allowances and adjust where necessary, to ensure that recipients can achieve Canada's Guidelines for Healthy Eating
* Make nutrition a primary determinant in agriculture food-product development
* Promote provincial food products based on their nutritional benefits

1.14 ESTABLISH A COORDINATING GROUP FOR INTERSECTORAL IMPLEMENTATION OF CANADA'S GUIDELINES FOR HEALTHY EATING

These guidelines should be jointly promoted as the single set of nutrition recommendations for communication to the healthy public over the age of two years of age. Group members should include representatives from nutrition and health professional organizations, food and related industries, non-governmental agencies, other government departments and the public.

1.15 ESTABLISH PUBLIC HEALTH NUTRITIONIST POSITIONS IN EACH HEALTH REGION

Staffing patterns in community nutrition services should be reviewed and adjusted to enable implementation of a comprehensive food and nutrition policy. Current nutrition services in the province are provided by home economists in the Departments of Health and Agriculture, and by dietitians linked to the Diabetes Education Resource [DER] programme. As DER dietitians work only with a specific population group, ie. people with diabetes, they do not address the broader needs of the general population. Because of the broad mandate of the home economics programme, nutrition is only one component of the overall workload. The resulting gaps in nutrition services were frequently identified in public briefs presented to the Task Force.

CHALLENGE II - COMMUNITY DEVELOPMENT

Communities want to be more involved in assessing needs and developing strategies to meet those needs. This message was loud and clear from the submissions and hearings held in Winnipeg and throughout rural and northern Manitoba.

RECOMMENDATIONS

2.1. ESTABLISH REGIONAL HEALTH PROMOTION COUNCILS

The Task Force recommends that Regional Health Promotion Councils (RHPC) be established in all health regions of the Province with broad representation from the community.

The purpose of the Councils is to encourage citizens in the regions to participate in the development of recommendations for comprehensive and cost effective health promotion activities/services. Council members from each region will meet as a Health Promotion Advisory Group to advise the Minister of Health.

The Task Force recommends that initially the Regional Health Promotion Councils focus on raising the profile of health promotion at the community level and within the health care system. The Regional Mental Health Councils are recommended as a prototype. A long term goal would be to expand to form Regional Health Councils, to include representation from all other sectors of the health care system (ie. acute care, long-term care, home care and private sector health care, care providers and board members of institutions and agencies).

2.2. EVALUATE CURRENT RESOURCE ALLOCATIONS AND UTILIZATION IN COMMUNITY HEALTH

In the light of Provincial Health Goals, present staffing complements and patterns should be reassessed. Public health program expectations have continued to increase, while numbers of staff to deliver programs has decreased. Currently there appears to be a shortage of community health workers to deliver the mandated programs, but there is no system in place to measure this perceived situation. The Health Promotion Task Force recommends that at the regional level a 'task analysis' be used to evaluate job descriptions, workloads, regional plans and work plans, and health department mandates, for their effectiveness in reaching provincial health goals. (See also 1.7.)

In rural communities, dietitian services are accessible through institutions and require physician referral. Dietitians with the Diabetes Education Resource work only with physician-referred diabetic clients. Services need to be expanded to community settings where the general public can have access to dietitian services.

Manitoba Health has 8.5 home economist positions in Norman, Thompson, Westman and Winnipeg Regions providing community nutrition services and financial counselling. Manitoba Agriculture has 17 home economists across the province, whose priority is financial management with farm families. Consequently, other non-qualified persons are establishing themselves as nutrition "experts".

More speech therapists and occupational therapists services should be made available to communities. There is a special need for preschool speech therapy as there is currently an 8 month waiting period for a preschool child to be seen by a speech therapist.

There are 23 community mental health workers in Winnipeg to take care of more than 1800 clients - a case load of 80 for each mental health worker.

2.3. MAKE INFORMATION AVAILABLE ON DIRECT AND INDIRECT HEALTH COSTS INCURRED IN THE REGIONS

To assist communities to understand the health needs of their individual community, they must understand where the money is presently being spent. As well as costs of medical treatment and care, costs of institutional care, hospitals, nursing homes, home care, and public health should be available to Regional Councils and citizens. The indirect costs of determinants of health such as poverty, unemployment, family violence, alcohol and drug use, and lack of lifeskills, must also be addressed. The current strategies of funding non-government organizations, community health centres, and other health delivery services and data specific to local health issues and health status should be made available to regional councils and citizens.

2.4. PUBLICIZE THE IMPACTS OF HEALTHY PUBLIC POLICY

If people are to understand the value of preventive care and health promotion, we must raise their awareness of the success of such approaches in achieving better health and in reducing costs. For example, the impact of seat belt laws on health care spending in Manitoba has not been widely publicized. The health implications of raising tobacco prices is another example.

2.5. PROVIDE OPPORTUNITIES FOR NURSES TO USE THEIR COMMUNITY DEVELOPMENT SKILLS

Nurses prepared in baccalaureate programs not only have knowledge and skills in working with individuals and families, but also have ready access to their communities through their work with individuals, families and groups. They have the necessary preparation and skills in assessing community needs, and collaborative skills for working with community groups. These skills are presently under-utilized due to current mandated priorities.

2.6. ACKNOWLEDGE AND UTILIZE COMMUNITY DEVELOPMENT EXPERTISE AVAILABLE THROUGH OTHER GOVERNMENT DEPARTMENTS AND NON-GOVERNMENT ORGANIZATIONS

For example, Agriculture Extension Services have effectively assisted in the development of Farm Women's Organizations based on a community development or extension program model. Some other examples which were brought to the attention of the Task Force include: Winnipeg Region's home economics young parents' group; Women's Institute; Pluri-elles.

> Through its many years of working with women, Pluri-elles has become aware of the need for Franco-Manitoban women to take charge of their own health.

2.7. REVISE CRITERIA FOR THE HEALTH SERVICES DEVELOPMENT FUND (HEALTH PROMOTION COMPETITION)

Give preference to those programs demonstrating community-based and multi-partnership planning as opposed to those programs designed and operated from health care institutions. An alternative is to create a separate small project fund, or category of HSDF. (See Recommendation 1.5)

2.8. EVALUATE CURRENTLY EXISTING COMMUNITY BASED HEALTH CENTRES

The Health Policy Centre at the University of Manitoba and/or the evaluation unit of Policy and Planning should study the cost-effectiveness of a salaried community health centre such as Hamiota, compared to fee-for-service in adjacent communities.

Community health centres appear to provide an ideal setting for improved access to multi-disciplinary health services. The Task Force heard a lot of support for the Community Health Centre concept. In community health centres, the commitment to health promoting, non-profit delivery systems, together with utilization of the appropriate, cost-effective professional and para-professional health care providers, is directed towards the effective use of health care dollars. A variety of care givers are accessible to consumers, (i.e. physicians, primary health care nurses, public health nurses, registered dietitians, health educators, social workers/counsellors, chiropractors, podiatrists, trained lay persons, etc.), and a variety of appropriate programs can be designed to meet community needs. (i.e. effective parenting, smoking cessation, drug abuse counselling, and support groups)

2.9 ENCOURAGE PHYSICIANS TO MAKE USE OF SUITABLE RESOURCE PEOPLE IN THEIR PRACTICES AND IN THE COMMUNITY TO PROMOTE A MULTIDISCIPLINARY APPROACH TO HEALTH CARE.

Presently services provided by many health professions are available only on referral by a physician. Cost is also a barrier to access of some of these services by the public. Manitoba Health Services Commission should consider covering services which are provided by health professionals including: dieticians, psychologists, physiotherapists, community mental health workers, family therapists.

A partial cost-minimization analysis of preschool immunization, comparing services delivered by public health nurses in Alberta with services delivered by private physicians in Ontario, suggests that immunization delivery, centred around the use of public health nurses, is as effective and more cost-efficient than a physician based fee-for-service system. In 1986, for every 10,000 fully immunized preschool children, Ontario paid approximately $184,000 more in labour costs than did Alberta. [Sadoway, Plain & Soskoline, 1990]

2.10 SUPPORT WELLNESS CENTRES FOR SENIORS

Community based wellness centres, are proposed as a cost-effective alternative to some of the more traditional types of medical treatment centers for older people. The anticipated growth in the senior population over the next twenty-five years, supports the need to develop innovative, wellness-oriented programs specifically for seniors. These programs should support and encourage the positive health practices already evident in the senior population. The "Choosing Wellness" program provide evidence of the success of this approach.

> 'Lions Place for Health provides services of a wellness and health promotion nature. Professional services that encourage self-responsibility for health, health maintenance, preventive programming, and postponement of disability are being developed. The services encourage the future older population to maintain a positive healthy, fit and active lifestyle'. [Lions PLace for Health]

2.11 ESTABLISH LINKS BETWEEN COMMUNITY-BASED AND HOSPITAL BASED PROGRAMS IN ORDER TO FOSTER COOPERATION AND INTEGRATION OF HEALTH PROMOTION ACTIVITIES

The provincial government and other health authorities should view hospitals as being more than curative facilities; they are part of a larger community, and as such have a responsibility to play an active role in health promotion.

Hospitals, in liaison with the Health Promotion Office, should develop guidelines outlining the aims and objectives of hospital involvement in health promotion. These will set out the particular areas of health promotion for which hospitals are best suited and will identify how hospital programs will interact in a synergistic fashion with community-based programs to ensure that all parts of the health promotion continuum are properly served.

Development of mechanisms for efficient and timely transfer of information, and for facilitating staff interaction between community and hospital programs will not only prevent unnecessary duplication but will also facilitate continuity of health promotion interventions for clients moving from the community into hospital and vice versa.

Facilitating the interaction of community and hospital-based personnel will permit both sectors to capitalize on their respective professional expertise, knowledge and skills in devising new approaches to effective health promotion.

Hospitals should exploit the existence of the diversity of professional disciplines within them in mounting health promotion programs that are multidisciplinary in their approach. The existence in some institutions of health promotion activities directed toward maternal/child care, nutrition, physical fitness, mental health, drug use/abuse, occupational safety, ergonomic adaptation to the workplace, and environmental controls, indicates the wide variety of initiatives hospitals can undertake successfully. Some of these initiatives are adaptations of approaches originally conceived in community settings, while others originated in the institutions.

Interaction between hospitals is also important so that the experience gained in a particular institution with health promotion activities can be shared with other institutions.

Funding for hospital health promotion should come from existing institutional budgets. It should not, under any circumstance, draw upon or prejudice those scarce resources currently directed toward community-based health promotion.

2.12 PROMOTE A COLLABORATIVE, COMMUNITY DEVELOPMENT APPROACH TO ADDRESS THE HEALTH NEEDS OF RURAL MANITOBANS AND FARM FAMILIES.

The rural population in Manitoba is declining as a percentage of the provincial population. Most of this decline is in farm population. With the depressed agricultural economy, the viability of rural Manitoba communities has suffered. Marital problems, violent behaviours, mental illness, depression and children's behaviour problems increase when people are experiencing financial problems.

Health risks to farm families include injury from machinery, animals and chemicals; stress related to work overload (on-farm and off-farm), financial circumstances, geographic isolation, and inter-generational family business relationships. Children are at particular risk for farm accidents. (Appendix E)

Health professionals need to communicate with people in the agriculture industry to develop an understanding of the rural life experience, in order to more effectively serve as resources for farm families. Working within a community development model, Manitoba Health staff should ensure participation of farm families in identifying community needs and accessing or developing local resources such as farm safety education, flexible child care, stress management programs, and support networks. Manitoba Health can also collaborate with the Departments of Agriculture and Rural Development in exploring diversification and new employment opportunities for rural communities, which should reduce health care and social costs in the future.

> **Ontario farmers are required to pass certification tests in order to purchase and apply pesticides.**

2.13 MANITOBA HEALTH SHOULD COLLABORATE WITH THE 'HEALTHY COMMUNITIES MANITOBA' INITIATIVE

Manitoba Health must collaborate with the Healthy Communities Manitoba Working Group which has been formed by amalgamation of the Strengthening Community Health Program and Canadian Healthy Communities initiatives. Several communities in Manitoba have adopted the healthy communities approach; these include Gimli, Flin Flon and Brandon. The Working Group will provide support to communities in developing and implementing local health projects. As a major player in health promotion, Manitoba Health should be represented on Healthy Communities Manitoba.

2.14 ENCOURAGE NON-GOVERNMENTAL ORGANIZATIONS TO EXAMINE THEIR PRACTICES AND RESOURCES WITH RESPECT TO WORKING WITHIN A PUBLIC INVOLVEMENT MODEL.

Manitoba Health should initiate on going knowledge development workshops. Those who are presently providing consultation and resources upon request to health professionals must be encouraged, and supported to work in partnership with government in using a community development approach to community health issues.

2.15. PROMOTE HEALTHY LIFESTYLES FOR MANITOBANS

The health sector over the past decade has been successful in promoting positive lifestyle changes in the Manitoba population including: decreasing smoking rates among most age groups, increasing daily physical activity, and decreasing consumption of saturated fats. Healthy lifestyles must continue to be actively promoted and a highly visible long range marketing plan and advertising campaign must be initiated. Consideration should be given to finding ways of making the healthy lifestyle message appropriate for all sectors of the Manitoban population. Efforts with other government departments that have similar mandate areas such as; Fitness Directorate, Recreation Directorate, City of Winnipeg Parks and Recreation, should be coordinated.

The move in Fitness toward 'active lifestyle' should be encouraged as a better alternative to current emphasis on exercise physiology. Fitness leadership development in communities should reflect this new approach to physical health.

'80% of all cancers are thought to be due to lifestyle and environmental factors. Risk factors for the most common cancers have been identified. The majority (80%) relate to environmental and lifestyle factors, the most important of which are smoking and diet. Sexual behavior, sunlight, consumption of alcohol and occupational carcinogens can be added to the list.' [Canadian Cancer Society]

According to Health & Welfare Canada, in 1982 the adverse consequences of tobacco related behaviour amounted to $7.12 billion. Consumer expenditures (of which 63% was government tax) amounted to $4.42 billion. In Manitoba, consumer spending and tax revenue were $186.5 million, whilst expenditures were $300.5 million.

Health promotion efforts have succeeded in reducing the prevalence of smoking amongst Canadians by 50% since 1968. However, one in three Canadians still smoke.

CHALLENGE III - REDUCING INEQUITIES

Differences in health status of sub-groups within populations have been clearly described and documented in many studies and reports. Factors such as education, literacy, housing, transportation, a clean water supply, employment, social support and economics greatly influence the health of an individual or family. There is a consistent strong association between low socio-economic status and poor health.

> **In 1986 Infant mortality rates in the lowest income group were double that of the highest**
>
> **Mothers with the lowest education were twice as likely to have a low birthweight baby than mothers with University level education**
>
> **Children whose families were below the poverty line had higher rates of chronic illness and functional limitations than other children [Winnipeg Harvest, Poverty Fact Sheet]**

It is our view that much of the current activity in health promotion is designed to reach the middle-class; lower socioeconomic status groups are often neglected. This stems in part from lack of training and experience in working with disadvantaged groups. Health promotion must address issues at all levels of Maslow's hierarchy of needs, if it is to be relevant to all sections of the population. (Appendix F)

> **'the present focus of health promotion is cardiovascular disease with an emphasis on nutrition and smoking intervention. Although cardiovascular disease is the major cause of death, many rural and remote communities do not identify this as a priority. In many cases, unemployment, inadequate housing, water and sewer services and environmental hazards are more significant issues to these communities. Regional programs realise social and economic development of communities is integral to the promotion of health and prevention of disease.' [Manitoba Health, Parklands Region]**

RECOMMENDATIONS

3.1 PLACE PRIORITY IN HEALTH PROMOTION ON ADDRESSING HIGH RISK GROUPS

Health promotion must refocus its efforts to reach those segments of the population most at risk, and adopt public policies which ensure that the basic conditions for health are provided to all Manitobans.

Inequities exist for groups such as the elderly, persons on low incomes, single mothers, aboriginal people, the unemployed, the homeless, new immigrants and refugees, the physically and mentally disabled, children and adolescents, gay men and women, blue-collar workers, and the urban poor.

3.2 IMPROVE THE DISTRIBUTION OF INFORMATION ABOUT HEALTH PROMOTION PROGRAMS AND SERVICES PRESENTLY AVAILABLE

Many presentations to the Task Force emphasized that dissemination of information regarding available health and related services is not effective. Therefore, many Manitobans are unaware of services available to them or how to access services. A Citizen Inquiry line for health and social related services, available toll free across the province, with local information being regularly updated, could be considered.

3.3 DEVELOP RESOURCE MATERIALS TO MEET A RANGE OF CULTURAL AND LITERACY NEEDS

Representatives of diverse cultural communities must be involved in the identification of needs and the development of materials to ensure that they are appropriate.

3.4. GIVE PRIORITY TO ENSURING AN ADEQUATE SUPPLY OF NUTRITIOUS AND AFFORDABLE FOOD IN NORTHERN MANITOBA.

While high food costs are experienced by all Northerners, the seriousness of their effect varies with individual and family circumstances. Many northern residents earn sufficiently high incomes to enable them to meet high food and living costs; however others, mainly Aboriginal people, who live in more isolated communities or in poverty in urban centres may have difficulty in obtaining sufficient nutritious food.

It is ironic that whilst alcohol is controlled through a government distribution system so that prices are identical across the province, basic food commodities are much more expensive in the North. [Appendix G]

> **In 1990 the average cost of feeding a family of four in Winnipeg was $120 per week, compared to $160 in Northern communities. [Nutritiou Food Basket, Agriculture Canada].In addition, heating and fuel costs are higher in the North, reducing the amount of disposal income available for food. The impact of the GST will probably exacerbate these problems.**

3.5. ADDRESS THE PRESSING ISSUE OF HUNGER, AND ENSURE THAT ALL MANITOBANS HAVE ENOUGH TO EAT.

It will be necessary for the Provincial Government to work with Municipalities, Non Government Organizations and Community Groups if this issue is to be effectively addressed.

The emergence of Food Banks in most major cities in Canada is a disturbing social phenomenon. Unknown ten years ago they now number over 200. An increasing number of people, many of them children, rely on Food Banks for their daily bread. Limited access to food, in a society with an abundant food supply, is not only likely to affect physical health but also to produce emotional and mental health stresses. About three-quarters of those relying on the Winnipeg Harvest food bank are people who are on some sort of assistance programme. The rest are 'working poor'.

> **12,000 people rely on the Winnipeg food bank every month. About 40% of those are children.** [Winnipeg Free Press, Sept. 23rd, 1990]

3.6. INCREASE COMMUNICATION AND COLLABORATION BETWEEN HEALTH AND FAMILY SERVICES

The Health and Family Services Departments should build upon existing working relationships to ensure cooperation and collaboration in program planning and service delivery to families. Families are at risk because of isolation, limited or non-existent social support networks, absence or non-existence of a spouse, poverty, or decreased coping skills. Services are needed which attempt to meet the needs of the family unit as a whole, as opposed to treating individual family members needs in isolation from one another.

3.7. RECRUIT AND UTILIZE CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICE PROVIDERS, COUNSELLORS, AND COMMUNITY WORKERS

3.8. EXAMINE THE IMPACT OF INCOME SUPPORT POLICIES ON HEALTH

It is questionable as to whether social assistance recipients and minimum-wage workers are able to meet their basic needs for food, clothing and shelter. Manitoba Health should work with Social Services to ensure that health is not jeopardized by insufficient income. [Appendix H]

Lack of affordable housing, is a chronic problem faced by many Manitobans, and compounded in the North by lack of sewer services and clean water. Heating and fuel costs are higher due to climatic conditions and high transportation costs. Thus, people spend more for these basic necessities reducing the money available for food.

3.9. REVIEW SOCIAL AND FAMILY SUPPORT PROGRAMS CONSIDERING THE NEEDS OF FARM FAMILIES

Farm families have high input costs combined with uncertain income related to the variables of weather and international commodity prices. Social and family support programs, such as housing and income support, should consider net family income versus gross farm income of farm families. This would more accurately reflect cash available for meeting family needs.

3.10 ENSURE THAT A STRONG HOME ECONOMICS SERVICE IS MAINTAINED

Recognize the role of the home economist as the professional trained to provide lifeskill education, including money management, food selection and preparation and family nutrition at the community level. The number of home economists in urban, rural and northern Manitoba is insufficient to meet the needs of low income families. As well a comprehensive central resource staff is necessary to support the training and resource needs of field personnel.

3.11 ENSURE THAT A STRONG PUBLIC HEALTH NURSING SERVICE IS MAINTAINED.

Public health nurses have worked with individuals, families and communities to promote health and prevent illness in Manitoba since 1916. The principles of health promotion and illness prevention are the foundation of the program areas of Maternal and Child Health, Communicable Disease Control, and Health Promotion, delivered by public health nurses.

The public health nurse, as the generalist in the community, provides service to all Manitobans. Existing public health nursing resources are stretched to the limit. It is imperative that sufficient numbers of public health nurses are maintained to provide this important health promoting service for all communities.

> ...the public health office should be made use of for a wider range of health promotion activities. Our public health nurses are familiar to many people in the community; they are non-threatening, and are viewed as sources of information already. Healthy people go to the public health nurse, seeking routine care, such as immunization of children to prenatal classes. [Morris Farm Women's Network]

> The MARN supports the primary health care model .. as a suitable model to be adapted to the present health care system. This would provide more effective health care to meet the needs of all Manitobans, regardless of place of residence. [Manitoba Association of Registered Nurses.]

3.12 CONSULT WITH ABORIGINAL PEOPLE AS TO HOW HEALTH NEEDS ARE ASSESSED AND ADDRESSED.

The Aboriginal people receive their health services from the Federal Government as well as the Province of Manitoba. The Task Force acknowledges that negotiations are in progress to solve the jurisdiction problem between the aboriginal people and the different levels of government. However, whilst the negotiations continue there is a need to address health promotion issues in consultation with aboriginal communities.

3.13 IDENTIFY RESOURCES REQUIRED BY, AND IN CONSULTATION WITH, ABORIGINAL COMMUNITIES

Resources required to develop and manage local health promotion and prevention initiatives need to be assessed. Community members have expressed a strong desire to manage their own local health promotion programs but require more education ie. counselling skills, program management skills, program development skills. Communities have expressed a strong desire to have their own members develop these skills so as to become self-sufficient. There may be an assumption that resources required by a community to be self sufficient are available, and the community merely needs to seek out these resources and use them. Perhaps certain resources do not exist and need to be developed.

3.14. MAKE SPECIFIC HEALTH PROMOTION PROGRAMS ACCESSIBLE TO THE ABORIGINAL COMMUNITIES.

Notwithstanding current programs and services, mental health and the prevention of diabetes are areas of expressed concern within the Aboriginal population.

Programs that are in place need to be evaluated for potential effectiveness. (These programs probably need to run for a longer period of time before effect could be seen on suicide rates and incidence of diabetes.) One needs to raise the following issues: All community members need to be considered, ie. pregnant women, children, elderly, teenager, political leaders. Each member has a role in the prevention of diabetes (adult onset) and promotion of mental health. Each community has valuable resources that can be used - elders, religious leaders, politicians, paraprofessionals, and professionals. However, other resources (as identified in 3.13) must be made available to the community.

3.15. PROVIDE EQUITABLE HEALTH SERVICES IN FRENCH

Provision of equitable health care services, programs and social services must be made available to the Francophone population, in rural and urban areas. Presently, many programs and resources as well as services are not available and there is a serious lack of French speaking health care service providers in all fields of health care and social services. We fully support the implementation of the recommendations of the Gauthier Report (French Language Services in Manitoba's Health Care Facilities October 1990) as a first step in improving French services in health care.

3.16 EXTEND FRENCH SERVICES TO COMMUNITY HEALTH, FAMILY SERVICES AND GENERAL HEALTH PROMOTION AND PREVENTION PROGRAMS.

This includes language training, professional training, and promotion of careers in health care.

3.17 ESTABLISH A FRANCOPHONE ADVISORY COMMITTEE

Manitoba Health needs a mechanism to advise it on matters relating to French language services in the field of community, health, family services and general health promotion and prevention programs at the provincial level. This Francophone Provincial Advisory Committee could study the needs expressed and determine what appropriate infrastructure and delivery system are required to provide adequate services. It would then be possible to identify the human resource requirements and implications regarding recruitment, education, and training.

3.18 ENSURE ADEQUATE AND ONGOING FINANCIAL AND HUMAN RESOURCES FOR CHILD AND YOUTH PROGRAMS.

Providing support to families, children and youth is an investment in the future. Focusing health promotion efforts on those in their reproductive, childbearing, childrearing and childhood years presents a unique opportunity to break the cycle of risk taking behaviour, and family dysfunctional states including violence and child abuse.

3.19 ESTABLISH A RESPONSIBILITY CENTRE FOR CHILDREN AND YOUTH.

A vehicle is needed to ensure communication, coordination and collaboration among agencies and government departments which provide service to children and youth. This centre, perhaps a directorate, would also promote continuity of service from birth through school age, and to individuals with special needs.

The United Nations Declaration on the Rights of Children should be recognized as the basis on which to establish healthy public policy in this arena.

3.20 INVOLVE CHILDREN AND YOUTH IN THE DEVELOPMENT OF POLICIES THAT AFFECT THEM.

To do this effectively, young people must be empowered to participate in decision-making. A partnership approach

between parents, children and youth, and 'helping' professionals and non-professional citizen groups is needed.

3.21 CONSIDER ESTABLISHMENT OF MORE SCHOOL-BASED HEALTH EDUCATION CENTRES WHICH TARGET THE SCHOOL POPULATION

The American experience of placing health centres in high schools should be considered. R.D. Parker Collegiate in Thompson is currently the only example in Manitoba. The centre provides health and educational support to students and has prevented many serious medical problems in the school age population.

3.22 SUPPORT SERVICES TO STREET CHILDREN THROUGH FUNDING OF STREET-YOUTH DROP-INS

> **Children's Home of Winnipeg has developed programs to meet the needs of youth. These include: RAP, a job training program for adolescent parents; TRY, a training resource for youth, and Parent-Support Program for those who are or might be abusive. [Keith Cooper, Children's Home of WInnipeg]**

3.23 EXPAND THE 'NOBODY'S PERFECT' PROGRAM OF PARENT EDUCATION AND SUPPORT.

The program is a collaborative effort, cost-shared between Manitoba Health and Health & Welfare Canada. Public health and community agencies have been trained to use it. Parent participants report increased knowledge and competence in parenting skills and the development of mutual support networks as a result.

3.24 INCREASE ACCESS TO REPRODUCTIVE HEALTH SERVICES FOR ALL MANITOBANS.

The promotion of healthy sexual development of children and young people must be a priority.

> **In a ten year period, sexually transmitted diseases tripled in Manitoba. Chlamydia, a cause of female infertility, rates were highest in the 15-19 year old female group and the 19-24 year old male group. [Statistics Canada]**

3.25 INVESTIGATE A GUARANTEED ANNUAL INCOME AS A POTENTIAL INSTRUMENT OF HEALTHY PUBLIC POLICY

Specific high risk groups such as pregnant women and nursing mothers should be the target, for guaranteed income. Inadequate social assistance rates make it very difficult for most Canadian welfare recipients and their children to have adequate meals. The link between malnutrition in pregnant mothers and impaired physical and mental development in young children is well documented.

Children of low-income families have twice the infant mortality rate, 2.5 times the rate of deaths from infectious diseases and twice as many accidental deaths.

Female single parents with children under 18 bore a full 17 percent of the poverty burden, even though they made up only 3% of all households.

On welfare, a single parent family with one child, 2 years old earns approximately $8,900.00. The poverty line income level is about $14,000.00, leaving a poverty gap of about $5,100.00.

Manitoba's incidence of children in poverty is higher than the national average. In Manitoba 23% of children under 18 live in poverty. This is more than 1 in 5 Manitoba children compared to the national figure of 1 in 6.

The most successful anti-poverty initiative of the federal government during the last decade was a series of increases in the Guaranteed Income Supplement for low-income seniors 65 and older. The combination of higher GIS payments and other pension improvements had a tremendous impact on elderly women, reducing their poverty rate from 42 percent in 1977 to 22 percent in 1987.

[Canadian Council on Social Development, 1990: Women and Poverty Revisited, 1990: Winnipeg Harvest Poverty Fact Sheet.]

3.26 DEVELOP AN INTEGRATED POLICY ON HEALTH AND FAMILY VIOLENCE.

This policy initiative will require the collaboration of the Alcoholism Foundation of Manitoba, Women's Health Directorate, Women's Directorate, Mental Health Directorate and other relevant directorates and agencies.

Abuse prevention and rehabilitation must address; alcohol/drug use, income, women's issues related to financial dependence, self-esteem, communication skills, parenting education and support, sex-role stereotypes, and respite for the caregivers of the elderly and disabled. There must be provision of adequate safe shelters, and counselling services for both victims and abusers in rural, northern, and urban locations.

> More than fourteen women in Manitoba have died since January 1989 as a consequence of domestic abuse. Last year, in Winnipeg alone, 680 domestic assault charges were laid in response to 846 reported assaults arising from 7,685 domestic calls.
>
> For fiscal year 1988-89, crisis shelters housed 1,921 women and 2,608 children, for a total of 17,711 nights. There were 28,000 crisis calls.
>
> Presently there are 9 crisis shelters, 8 second stage housing, and 6 rural wife abuse committees in Manitoba.
> [Winnipeg Free Press, 1990]

3.27 SUPPORT THE DEVELOPMENT OF WORKPLACE HEALTH AND SAFETY PROGRAMS

Health promotion programs must focus on the workplace environment which affects both the mental and physical wellness of workers. An example of modern day exposures which will have a future impact on WCB costs is the use of video display terminals and the importance of adhering to ergonomic standards. Lighting, rest, time, seating, etc. affect both the mental and physical state of workers. Also, lung function exposures require adequate workplace standards. Manitoba has adequate Workplace Safety and Health legislation in place but enforcement of these standards remains 'toothless' due to a serious shortage of inspectors and expertise.

In 1988 there were 52,872 work-related accidents and 46 fatalities reported to the Manitoba Workers Compensation Board. The Manitoba workers compensation board paid $132,419,000 in 1988 for medical aid, compensation benefits, rehabilitation and pensions for workers injured on the job. [Occupational Health Centre, Manitoba Federation of Labour]

3.28 ADDRESS HIV INFECTION.

Risk activities for HIV infection and other sexually transmitted diseases have been well documented. In order to reduce and prevent HIV transmission, at-risk individuals must personalize their risk. Secondly, they must wish to reduce their risk and perceive themselves as being capable of doing so.

Existing government and non-government programmes require reassessment to ensure that health/social service programmes are designed to consider the comprehensive needs of the individual.

Models which enable people to take control over their behaviour must be an integral component of generic health promotion programming.

It is imperative that specific counselling prior to and following HIV antibody testing, be encouraged to not only ensure informed consent, but also to provide personalized education and risk-reduction alternatives.

Swampy Cree Tribal Council has a community based AIDS prevention project initiated and led by community leaders, elders, aboriginal workers, and band chiefs and councils.

'The AIDS Project' sponsored by the Manitoba Museum of Man and Nature is an example of innovative education for the community. This exhibit places AIDS in a broad historical and social context.

'Street Links' is an innovative health promotion project designed to reach high risk groups. Health professionals travel to a variety of street sites to bring health information including HIV risk reduction information.

3.29 CONTINUE TO FUND AND SUPPORT THE ELDERLY IN IDENTIFYING AND ADDRESSING THEIR HEALTH PROMOTION NEEDS

Programs such as those offered through Age & Opportunity, Creative Retirement, Society of Seniors are excellent examples that promote the physical and mental well-being of seniors. These and other groups may need special training in extending their outreach efforts to those who are poor and isolated from the mainstream.

> The focus must be toward independent living - sustained and enhanced by self-responsibility and participant-oriented, rather than recipient-targeted services. It must, in part, be consumer-driven, where the consumer is really a client/participant with control over the choices and options. The emphasis must be on wellness, creating a situation which enhances and maintains (and is perceived to enhance and maintain) self-independence within the context of concern for total well-being - physical, social, mental, and spiritual. [Creative Retirement]

> 'Footloose and Fancy Free' is a recreational program that was initiated by the Manitoba Society of Seniors in cooperation with 14 other agencies. As part of the program, 18 shopping centres, schools, community clubs and seniors centres across Manitoba have opened their doors to seniors for walking/jogging, providing a safe and climate controlled facility for physical activity. In Winnipeg, 8 shopping centres are now opening their doors from 7:30-9:30 a.m. for Footloose participants. [Manitoba Society of Seniors.]

CHALLENGE IV EDUCATION AND RESEARCH

Good health promotion practice requires a strong theoretical, philosophical and technical base. Many professionals and community groups have a role to play in health promotion. However, there is little formal education and training available in health promotion theory, strategies and skills - at any level. Whether we are looking at comprehensive university courses for health professionals, or skills training for lay persons, there is a great need for educational development in this field.

The limited documentation which is available regarding the efficiency and effectiveness of health promotion indicates that it is a valuable strategy in improving health and has met with considerable success. More research funding is necessary to elicit the health benefits and costs of health promotion initiatives and to establish a greater data base to demonstrate effectiveness of practice. The development of health indicators is one such need.

4.1. STRENGTHEN LINKS WITH EDUCATIONAL INSTITUTIONS

Links between practice and teaching theory are essential to health promotion. These can be achieved through: a) cross appointments with educational institutions and government agencies; b) establishing health promotion internships for students in government departments and agencies; c) initiating inservices and continuing education for government employees in new health promotion methods and research.

Presently, universities in Manitoba are training health care professionals to practice health promotion in a variety of settings. For example the University of Manitoba School of Nursing, Faculty of Human Ecology, and Faculty of Education are producing knowledgeable and capable graduates prepared to practice health promotion. However, a gap continues to exist between the graduates who have been educated to practise health promotion and the nature of the workplaces available and the number of employment opportunities where health promotion can be implemented.

Manitoba Health and the Universities must continue to work together to train and employ these skilled graduates. More opportunities for practicum experiences working with communities must be encouraged and rural and remote settings and facilities must be utilized as practicum sites.

4.2 INCORPORATE HEALTH PROMOTION INTO PROFESSIONAL EDUCATION AND TRAINING

Health promotion should be an integral component in the undergraduate curricula of all health and allied professionals. Particular attention should be given to: physicians, nurses, dietitians/nutritionists, home economists, dentists, social workers, psychologists, and pharmacists. Provision should also be made for continuing education opportunities and for regular in-services.

4.3 CONTINUE TO FUND ABORIGINAL AND IMMIGRANT ACCESS TO PROFESSIONAL HEALTH CARE EDUCATION

There is a continued need to have increased numbers of professional health care providers who reflect the ethnic and cultural makeup of the community. According to the Indian and Inuit Nurses of Canada (IINC), Manitoba aboriginal nurse registry, there are as of January 1991, 7 baccalaureate degree trained nurses. Of these. 6 are Status Indians. There are 60,000 Status Indians in Manitoba.

The Health Promotion Task Force is aware that funding for the following affirmative action programs are tenuous and deems it critical that funding continues.

a) The Northern Bachelor of Nursing Program (NBNP) for registered nurses is located in the Pas and funded by the Swampy Cree Tribal Council - 60% and the Province of Manitoba - 40%. This program provides the opportunity for aboriginal and northern nurses to earn a bachelors degree in nursing in the north. The emphasis of the program is on nursing roles in primary health care: partnership with community groups in the promotion, conservation, and restoration of health and the prevention and amelioration of illness and disability. The program is a result of collaboration between the Swampy Cree Tribal Council, the Province of Manitoba, the Medical Services Branch of the Department of Health and Welfare, and the University of Manitoba. The impetus for the program came from the Swampy Cree Tribal Council.

b) The provision of access to affirmative action programs in health care education has been successful in increasing the number of Aboriginal and immigrant health care providers. However, the question as to whether or not adequate numbers have been achieved must be raised. According to the IINC Manitoba aboriginal nurse registry 78 known registered

Aboriginal nurses have received their nursing education in Manitoba. These numbers are affected each year by various nursing education programs in Manitoba. The Southern Nursing at Red River Community College, is funded by the province and money is recovered from the federal government for Status Indian student education. Immigrant aboriginal people and single parents gain access to diploma nursing education.

c) The Special Premedical Studies Program (SPSP), University of Manitoba.
Students who have completed the Special Premedical Studies Program, run by the University of Manitoba Access Program, have gone on to graduate in health careers. As of January, of the students completing the SPSP, there has been a 100% graduation rate once the students have obtained admission to the professional health faculties.

> As of January, 1991; Medical - 5; Dentistry - 3; Pharmacy - 1; Med. Rehab. -1; Nursing -3;; Arts. - 10, Human Ecology. - 2; Social Work - 2; Education - 3.

4.4 SUPPORT NORTHERNERS ACCESS TO PROFESSIONAL HEALTH CARE EDUCATION IN THE NORTH.

To recruit and retain adequate numbers of professional health care providers and health educators in northern communities, training should be available in the North. Programs such as those offered at Keewatin Community College should be supported and strengthened. The Northern Nursing Program in Thompson provides opportunity to northern residents to gain a diploma in nursing; graduates tend to stay in the North.

> Of the total graduates since 1986, 78% are presently employed in Northern Manitoba; 5% are employed in Northern Saskatchewan; 5% in Northern B.C.; 5% in NWT; 2% in NFLD; 2% in the USA and 3% are unknown employment locations.

4.5 EVALUATE CURRENT PARAPROFESSIONAL TRAINING PROGRAMS AND INCREASE THE EMPHASIS ON HEALTH PROMOTION

Community Health Workers provide an innovative means of delivering community health services in the North. Whilst they undertake some health promotion activities there is potential for substantial expansion to reach geographically isolated and marginalized target groups.

4.6 SUPPORT COMMUNITY COLLABORATION WITH EDUCATIONAL INSTITUTIONS

Programs should be developed which meet community needs and support development of participative research strategies. Provide stepwise progression for trained paraprofessionals and lay community members to continue on to professional training. School Divisions should support the efforts of other community groups to carry out local health promotion projects but should not be expected to carry the burden alone.

> Over the past decade, we have seen a transfer of responsibility from other care agencies to education for children with social, emotional and/or physical problems. We find ourselves providing a level of care which, in previous decades, was undertaken by the family and/or health and social agencies outside the school system. The provision of physiotherapy, behavioural modification, care and supervision has fallen increasingly upon the school system. There is, in our opinion, a need for the highest level within Government to address the need of cooperation between the caring agencies and education. Jurisdictional disputes over "turf" often affect our ability to look at the individual client and meet that client's needs. [Evergreen School Division]

4.7 CONTINUE TO SUPPORT THE DEVELOPMENT OF CORE CURRICULA IN HEALTH IN HEALTH PROMOTION

Today, there is widespread support for health education as a priority in educational institutions at all levels.

The University of Manitoba, Faculty of Education should offer a Health Education Major for students wishing to specialize in health education. Schools should be encouraged to have teachers trained in health education to provide expertise in health issues within the school. Inservice sessions delivered by Manitoba Education and Training and Manitoba Health staff are important supports to ensure that educators remain up-to-date on health topics.

4.8. ENCOURAGE AND SUPPORT SCHOOL HOME ECONOMICS PROGRAMS.

The Junior High Home Economics program is an important source of information for students on nutrition education, food preparation, clothing, decision making, consumer education, and family living. In a period of declining revenues and recession, these courses present vital skills to students and their families.

The Family Studies curriculum in high school emphasizes child development, parenting and family living, important content for students to study in a time of family instability. Learning about children and families assists students to better understand themselves.

> **In 1989/90, enrollment figures show that out of 30,000 Home Economics students 10,546 were males. These male students participated in Food and Nutrition, Family Studies, and Clothing, Housing and Design courses. The most popular in-depth course at the high school level was Family Studies. [Manitoba Education & Training]**

4.9 CONTINUE TO ENCOURAGE AND SUPPORT HOME ECONOMICS, FAMILY STUDIES PROGRAMS FOR ADOLESCENT PARENTS

The current initiative includes some facilities support from Manitoba Education and Training as well as a program of lifeskills and academic courses to help students complete high school and to develop parenting and "survival" skills.

4.10 EXPAND THE IN-SERVICE TRAINING OF REGIONAL HEALTH STAFF IN THE PROCESS AND SKILLS OF COMMUNITY MOBILIZATION

Health Promotion is a relatively new concept and professionals schooled in traditional health education need to be updated on the process of working with a community. Additional training will support staff in helping communities help themselves by sharing information, resources and expertise with community members and fostering public participation and local leadership.

4.11 CONTINUE TO SUPPORT INTER-DEPARTMENTAL COLLABORATION BETWEEN MANITOBA HEALTH AND MANITOBA EDUCATION AND TRAINING

A combination of health professionals and educators is vital to the effective delivery of the programs, and in the review and implementation of health education curricula such as Health Education, AIDS Education, and Family Life Education. Recognition should be given to this need for cross-department work, and staff encouraged and supported in such endeavours.

4.12 ESTABLISH AND MAINTAIN A HEALTH PROMOTION CLEARINGHOUSE

To utilize resources effectively and efficiently, communities, health professionals and non-governmental organizations need ready access to up to date data and resources. The Ontario Prevention Clearinghouse which provides an information database on research, expertise and educational resources is a model example. [Appendix I].

4.13 SUPPORT INTERSECTORAL COOPERATION BY THE PROVISION OF APPROPRIATE EDUCATIONAL OPPORTUNITIES

Conferences, symposia, training sessions and public forums all serve to increase knowledge and skill development among public servants, private sector employees, non-profit health agency staff, health professionals, academics and the general public.

The Winnipeg Community Conference, 'Women and AIDS', held in November, 1990, was an example of a conference involving a number of community groups working with Manitoba Health to design and plan an event to meet local needs.

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PRESENTATIONS AND SUBMISSIONS TO THE HEALTH PROMOTION TASK FORCE BY ORGANIZATIONS AND GROUPS

Adult Children of Alcoholics
Alcoholism Foundation of Manitoba
Association des directeurs et directrices des Eccles franco-manitobaines
Aurora House, The Pas
Brandon AIDS Support Inc.
Brandon General Hospital, School of Nursing
Brandon University. Department Nursing & Health Studies,
Canadian Cancer Society
Canadian Co-Operative Association
Canadian Council of Cardiovascular Nurses
Canadian Diabetes Associating, Swan River
Canadian Diabetes Association, Manitoba Division
Canadian Mental Health Association, Manitoba
Canadian Mental Health Association, Selkirk
Chemical Abuse Education Program, Selkirk
Child Protection Centre
Citizens Eyecare Education
College of Physicians & Surgeons of Manitoba
Committee on Unplanned Pregnancy
Community Holistic Circle Healing, Hollow Water Band
Concerned Citizens for Health Care, Thompson.
Conseil de la cooperation du Manitoba
Consumers Health Organization of Manitoba
Creative Retirement Manitoba
Dakota Ojibway Tribal Council
District de la Sante Notre Dame de Lourdes
Evergreen School Division
Family Services of Winnipeg Inc.
Federation provinciale des comites de parents .
Gatekeepers, Thompson
Gimli Health Promotion Committee
Hamiota District Health Centre
Health and Welfare Canada, Health Promotion Directorate, Prairie Region
Health Educators Interest Group
Health Sciences Centre, Educational Resources and Biomedical Communications Unit
Interlake Health Unit Advisory Board
INCO Health & Safety Division, Thompson
Johnson Memorial Hospital, Gimli
Keewatin Community College
Kinsmen Reh-fit Centre
Lions Place for Health
Manitoba Action Committee on the Status of Women
Manitoba Agriculture, Home Economics Section
Manitoba Agriculture, Home Economics, Northwest Region
Manitoba Agriculture, Home Economics, Steinbach
Manitoba Association of Community Health Centres
Manitoba Association of Home Economists

Manitoba Association of Home Economists, Parkland Branch
Manitoba Association of Registered Dietitians
Manitoba Association of Registered Nurses
Manitoba Association of Registered Nurses; subcommittee on family violence
Manitoba Committee for Fitness Appraisal, Certification and Accreditation
Manitoba Community Nurses Interest Group
Manitoba Culture, Heritage & Recreation
Manitoba Dental Association
Manitoba Education and Training
Manitoba Federation of Labour, Occupational Health Centre
Manitoba Fitness Directorate
Manitoba Head Injury Association
Manitoba Health Organizations Inc.
Manitoba Health & Family Services, Central Region
Manitoba Health, Dental Health Directorate
Manitoba Health & Family Services, Eastman Region
Manitoba Health, Health Promotion Directorate
Manitoba Health, Information Resources Centre
Manitoba Health & Family Services, Interlake Health Promotion Committee
Manitoba Health, Maternal & Child Health Directorate
Manitoba Health, Mental Health
Manitoba Health & Family Services, Norman Region
Manitoba Health & Family Services, Parklands Region
Manitoba Health,& Family Services, Services to Seniors (Eastman)
Manitoba Health & Family Services, Thompson Region
Manitoba Health & Family Services, Westman Region
Manitoba Health; Dental Health, Western District
Manitoba Home Birth Network
Manitoba League of the Physically Handicapped: Souris & District Branch
Manitoba Lung Association
Manitoba Medical Association
Manitoba Parks & Recreation Association
Manitoba Pharmaceutical Association
Manitoba Public Health Association
Manitoba Women's Institute
Morris Farm Women's Group
Morris-MacDonald School Division
Mount Carmel Clinic
Occupational Health Nurses Interest Group
Pan Am Fitness Professionals
Pembina Valley Pregnancy Crisis Centre
Planned Parenthood Manitoba
Pluri-Elles
Portage Advisory Committee on Smoking
Portage la Prairie & District Arts Council
Psychological Association of Manitoba
Recreation for Life , Dauphin.
Red River Valley Health District
Regional Women's Resource Centre Coalition

Riverdale Place Homes, Arborg
Rural Health Educators
Russell Concerned Citizens
St. Pierre - St. Jean Child & Family Resource Centre
Selkirk HUB Committee
Selkirk P.R.I.D.E
Seniors for Seniors Co-Op Inc., Brandon
Seven Regions Health Centre
Societe Franco Manitobaine
Society for Depression & Manic Depression of Manitoba Inc.
Souris Health District
Steinbach Family Medical Centre
Target Fitness Centre
Taxicab Industry Employees Group
The Pas Friendship Centre
The Pas Health Complex Inc.
University of Manitoba, Preventive Dental Sciences
University of Manitoba, School of Dental Hygiene,
University of Manitoba, School of Nursing
Virden ADAPT
West Region Tribal Council
Women's Health Clinic
Women's Health Research Foundation
YM-YWCA of Winnipeg
YMCA Heart Rehabilitation Program, Brandon
Youville Clinic
YWCA - Thompson

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Mr. Ken Gregory, Arborg
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Mr. Dale Hoffman, Morris
Mr. Gestur Jakobsen, Arborg
Ms Bernice Marmel, Winnipeg
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Ms Margaret Mitchell, Brandon
Ms Pat Martens, Kleefeld
Ms Carolyn Poitras, Russell
Ms Sylvia Sigurdson, Arborg
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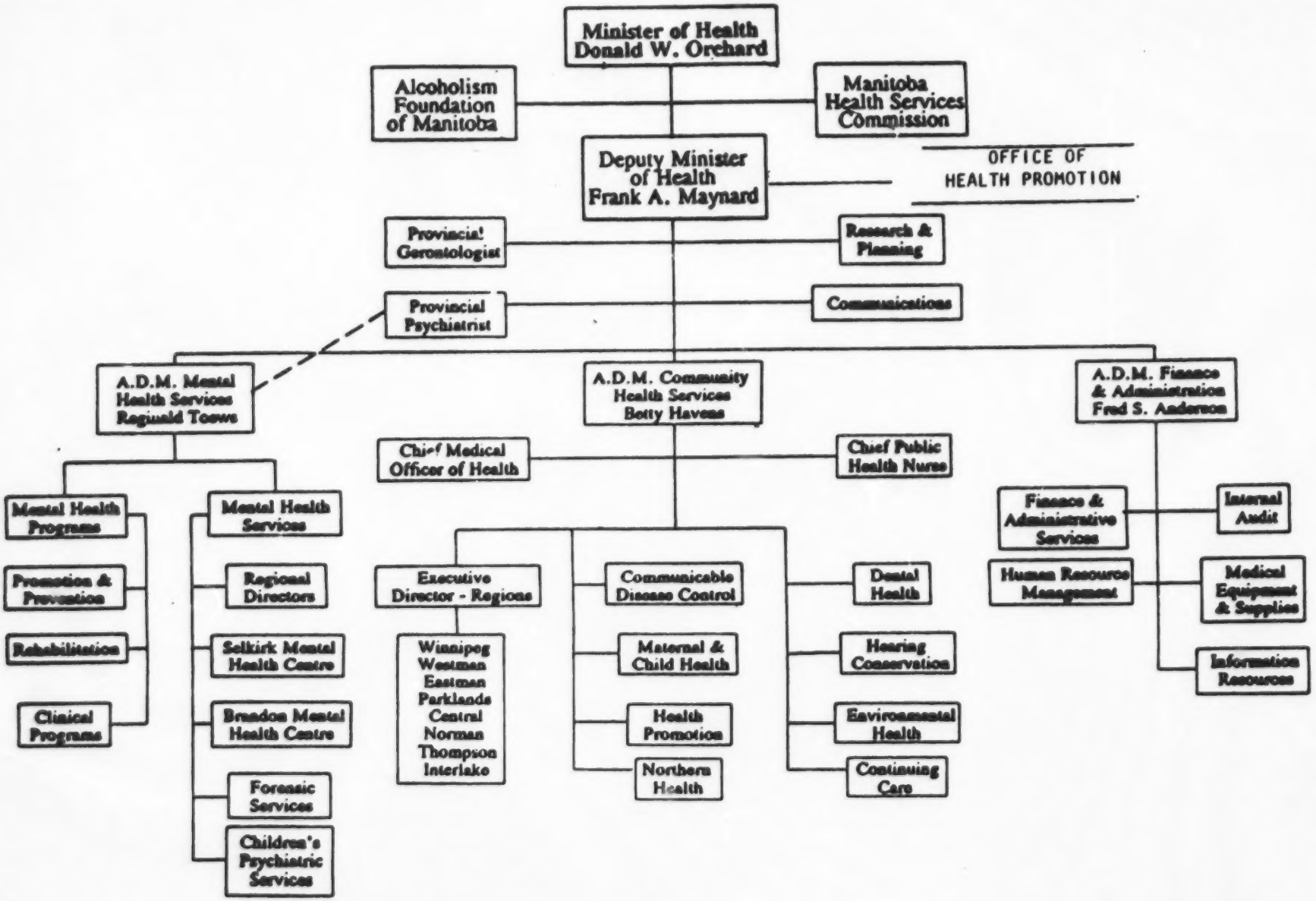
Dr. Nina Chappell
Mr. Keith Cooper
Dr. Nancy Hall
Dr. Pran Manga
Dr. Brian Postl
Dr. Michael Rachlis
Dr. John Wade

GLOSSARY

Canadian Healthy Communities	Formed in response to the Epp report 'Achieving Health For All', it's goal is to get municipalities to improve their physical and social environments. The project is sponsored by the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities.
Community Development	A strategy involving partnership with community members to solve problems and build strength, self-sufficiency and well-being
Determinants of Health	The basic conditions on which health depends. Determinants include genetic endowment, environmental factors (e.g.. air, water, shelter, employment, literacy), nutrition, occupational health, lifestyle and access to services
Disease Prevention	Health efforts focusing on individuals or groups who are specifically at risk for identified diseases.
Food Security	A condition in which all people at all times have access to nutritionally adequate, safe foods, from normal food channels.
Health	The extent to which an individual or group is able on the on hand, to realise aspirations and satisfy needs, and on the other hand to change or cope with the environment. It is a positive concept emphasizing social and personal resources as well as physical capacities.
Health Indicators	Proxy measures of the health status of a community or population. Health indicators are distinguished from traditional indicators of ill-health such as morbidity and mortality statistics.
Health Promotion	The process of enabling people to increase control over and to improve their health.

Healthy Lifestyles	Ways of living which incorporate health enhancing habits and routines and which avoid personal behaviours detrimental to health.
Healthy Public Policy	Policy in many fields which enhances health.
Inequities	Systematic inequalities in health which result from differential access to services and material living standards.
Intersectoral	Involving the joint efforts of individuals or organizations from different spheres of influence, such as: government departments, non governmental agencies, businesses, community groups, professional associations.
Strengthening Community Health	An initiative arising out of the Epp report 'Achieving Health for All', and focused on identifying needs and developing strategies and resources to enable collective community health action. Emphasizing public participation, the project is sponsored by the Canadian Public Health Association.

Organization Chart - Manitoba Health (as at March 31, 1990)



APPENDIX A

APPENDIX B

Manitoba Government NEWS RELEASE

Manitoba

Information Services, Room 29, Legislative Building, Winnipeg, Manitoba R3C 0V8

Telephone: (204) 945-3746
Fax: (204) 945-3988

August 3, 1990

FIRST PROJECTS ANNOUNCED FOR HEALTH DEVELOPMENT FUND

\- - -

$8.2 Million Over Three Years Allocated to 13 Projects

Health Minister Donald W. Orchard has announced the first projects approved for funding by the new Health Services Development Fund.

"These 13 projects reflect new programs aimed at innovation, cost containment or improved health," said Orchard.

The project costs total $8.2 million over three years with $3.2 million approved for 1990-91. Funds channelled through the Health Services Development Fund come from an annual allocation of $10 million in provincial casino revenues. Applications will be reviewed on an ongoing basis and additional projects will be announced later this year.

The 13 approved projects were among 122 proposals received after the Health Services Development Fund was announced in September 1989. A steering committee, chaired by Deputy Minister of Health Frank A. Maynard, oversees the management of the fund, reviews individual applications and recommends projects for approval by the minister of health.

The projects approved fall into three categories: innovative programming, health promotion and disease prevention, and equipment acquisition. One major project approved was the creation of the Manitoba Centre for Health Policy and Evaluation. It will be funded over a three-year period for an estimated $3.5 million.

- more -

Other projects focus on areas such as cardio-vascular education (two separate projects at Carman and Brandon hospitals), dialysis services, diabetes awareness, head injury prevention, back injury prevention, mental health (three separate projects - self-help, employment and chronic care), chemical dependency in seniors, St. Boniface Hospital out-patient centre and the Westman Integrated Strategy for Health Study.

Cc

APPENDIX C

RECOMMENDATION: DEVELOP A QUALITY ASSURANCE PROGRAMME

Today's society is under an enormous pressure to reduce costs, while at the same time maintain quality.

The single most useful tool which will enable us to meet these objectives is to systematically analyze the work being done and to establish appropriate standards and procedures. This completed ensures that they are performed consistently and in the proper manner.

Defined, a **Quality Assurance Programme** is nothing more than knowing what it is you want to accomplish.

To assist government programme co-ordinators in applying a systematic approach, there are ten aspects to implement. They are as follows:

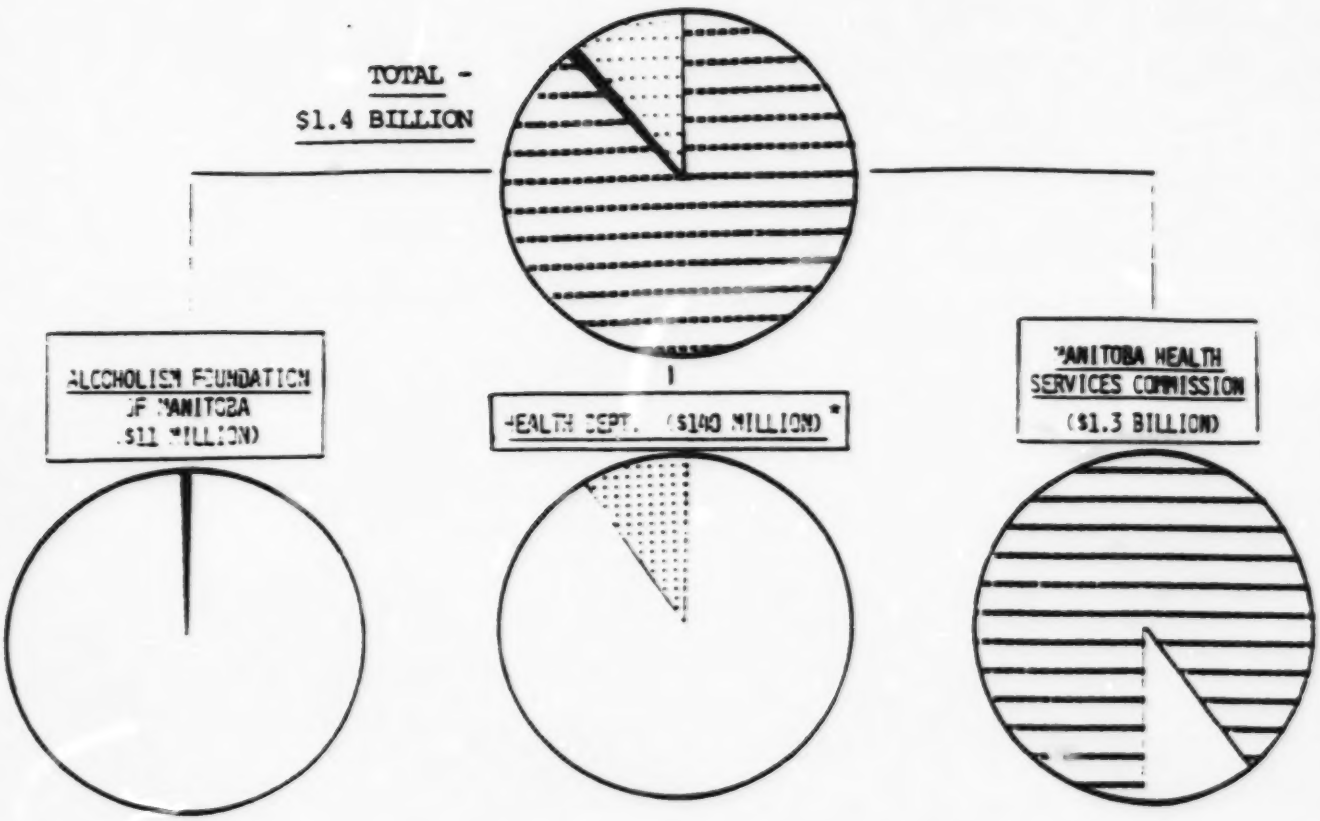
1. Inventory All Occupations
2. Inventory The Tasks For Each
3. Identify The Critical Tasks
4. Break Tasks Down Into Steps
5. Pinpoint The Loss Exposures (Where do the vulnerabilities exist?)
6. Make An Efficiency Check (for both people and work places) (Test the task procedure to ensure it can work, ask the workers!)
7. Develop Controls (to ensure work can be completed error free)
8. Write The Procedures
9. Implement
10. Update And Maintain Records

It should be stated that one of the reasons government spending will continue to excellerate is that quality assurance is not in place.

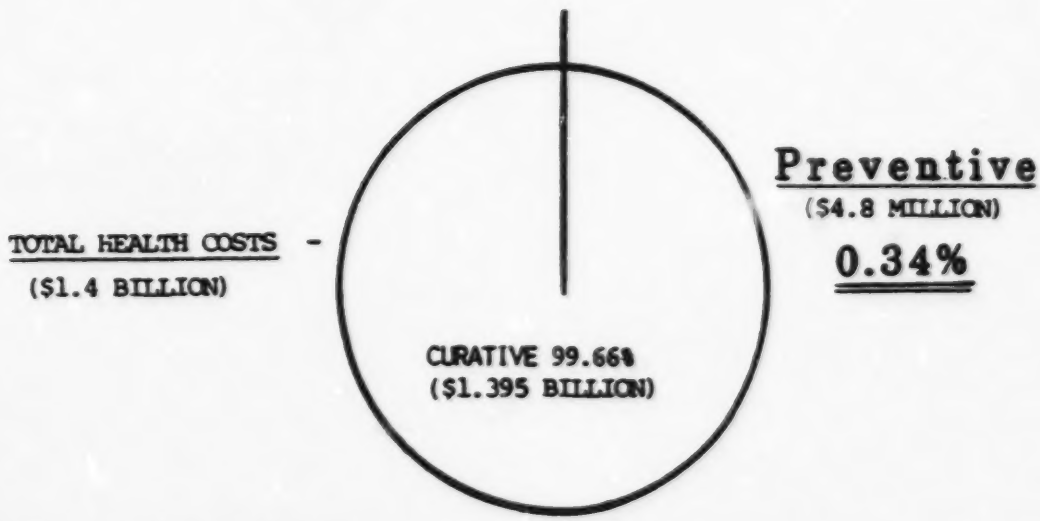
APPENDIX D

Manitoba Health Costs

1988/89


TOTAL -
$1.4 BILLION
ALCOHOLISM FOUNDATION OF MANITOBA ($11 MILLION)
HEALTH DEPT. ($140 MILLION)*
MANITOBA HEALTH SERVICES COMMISSION ($1.3 BILLION)

Health Promotion Costs *



* Based on 1988/89 Estimates

APPENDIX B

AGRICULTURALLY RELATED HOSPITALIZATIONS - MANITOBA

ACCIDENTS BY AGE GROUPS

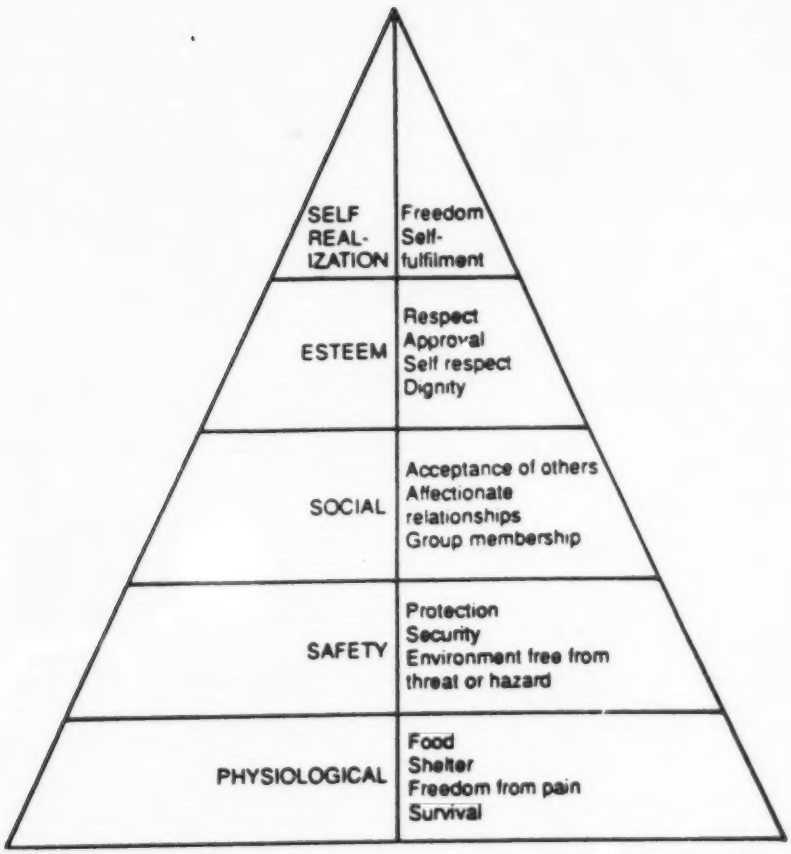
AGE GROUP	1990*	1989	1988	1987	1986	1985	1984
1-4	1	2	6	5	8	3	6
5-9	4	12	13	9	4	3	11
10-15	7	15	24	35	12	19	18
16-25	9	27	31	42	26	31	27
26-45	29	71	62	66	59	72	54
46-65	27	69	78	63	54	52	51
> 65	8	14	21	21	15	25	23
TOTAL	85	210	235	241	178	205	190

* To June 30th

Source: Manitoba Labour: Workplace, Safety and Health

APPENDIX F

MASLOW'S HIERARCHY OF HUMAN NEEDS



APPENDIX G

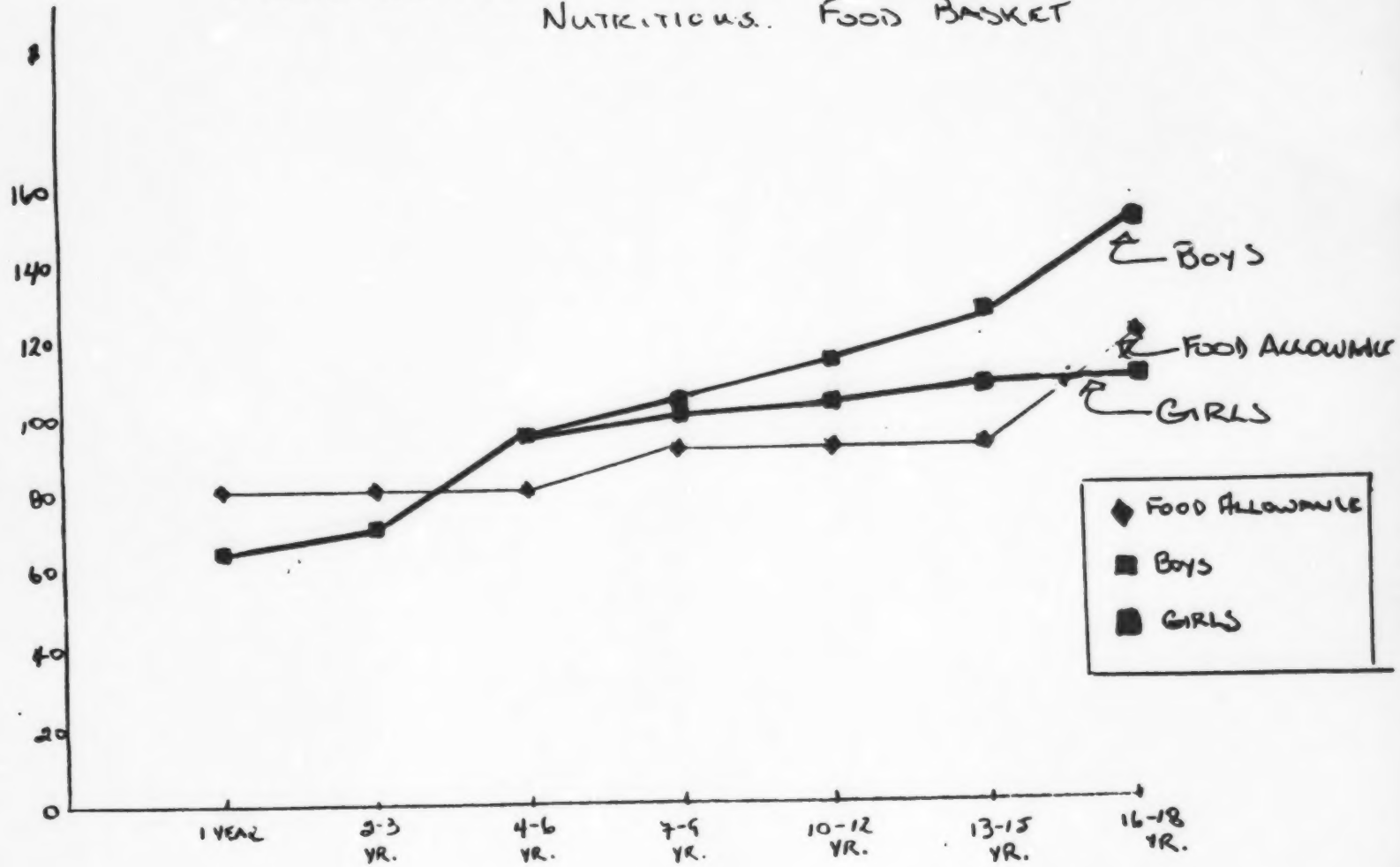
FOOD FOR HOME CONSUMPTION SPATIAL RETAIL PRICE INDICES FOR SELECTED MANITOBA COMMUNITIES

	BRANDON	FLIN FLON	ISLAND LAKE	LEAF RAPIDS	NORWAY HOUSE	THE PAS	THOMPSON
	WINNIPEG = 100				DECEMBER 1989		
DAIRY PRODUCTS	101.9	109.5	180.3	125.1	120.2	114.9	104.9
CEREAL & BAKERY PRODUCTS	105.7	117.8	144.9	131.3	118.7	115.8	109.8
FATS & OILS	105.9	110.7	145.7	111.4	124.1	116.7	105.5
MEAT, POULTRY & FISH	113.7	120.6	147.7	133.8	117.9	122.4	121.1
EGGS	110.2	134.1	167.5	141.5	118.7	132.9	90.2
FRUITS & VEGETABLES	119.3	134.6	215.4	158.5	135.2	126.6	125.7
FROZEN FOODS	114.1	106.7	174.7	135.3	125.9	118.3	113.0
DISHES & SNACKS	109.5	104.8	184.9	144.1	150.5	121.1	116.2
OTHER FOODS	103.7	110.5	147.4	119.5	115.6	114.0	107.2
BEVERAGES	100.3	108.8	156.9	119.7	118.5	113.1	111.1
COMMUNITY INDEX	109.3	118.1	166.8	133.6	122.1	119.3	114.5

DATA SOURCE: MANITOBA BUREAU OF STATISTICS, PRICES MONITORING SURVEY.

APPENDIX H

PROVINCIAL FOOD ALLOWANCE (1991) VS AGRICULTURE CANADA'S NUTRITIOUS FOOD BASKET (DEC 1990)



APPENDIX I

PROGRAM OBJECTIVES
OF
THE ONTARIO PREVENTION CLEARINGHOUSE

The purpose of the Ontario Prevention Clearinghouse is:

To increase province-wide awareness of prevention alternatives by providing for information exchange within the emerging fields of health promotion and primary prevention.

To operate an information centre for health promotion and primary prevention programs concerned with the social, emotional and physical well-being of individuals, families, and communities, including resources, research, evaluation, and related activities in Ontario and other jurisdictions.

To further develop and maintain a database of health promotion and primary prevention-related activities, utilizing existing information when possible,

To facilitate :

* an information exchange and networking among individuals and organizations involved in health promotion and primary prevention throughout Ontario;

* an increased awareness of health promotion and primary prevention issues among service providers and funders;

* public and professional education in the concepts and practices inherent in health promotion and primary prevention;

* planning, development, and implementation of health promotion and primary prevention initiatives within the province of Ontario.